Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4928HIC	A. BUILDING _____ B. WING _____	04/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOSPICE DEL SOL	3634 N RANCHO LAS VEGAS, NV 89130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Focus State Licensure Survey conducted in your facility on April 21, 2011, in accordance with Nevada Administrative Code, Chapter 449, Provision of Hospice Care. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The current census was fourteen. Three patient records were reviewed. One Home visit was conducted. Seven employee files were reviewed. The following regulatory deficiencies were identified.	L 000		
L 064	449.0185 REQUIREMENTS OF PROGRAM OF HOSPICE CARE A program of hospice care must comply with the following requirements: 7. Home health aide and homemaker services must be available to each patient and provided at intervals which meet the needs of each patient. A registered nurse must: (a) Supervise the persons providing such services; and (b) Prepare written instructions for the persons providing such services which identify the duties they are to perform. This Regulation is not met as evidenced by: Based on record review and interview, the agency	L 064		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 064	Continued From page 1 failed to ensure the nursing care provided by a certified nurse assistant (C.N.A.) was under the supervision of a registered nurse for 1 or 3 patients, (Patients #1). 1. Patient #1 Review of the record revealed no documented evidence of supervision of the C.N.A. by a Registered Nurse since 3/1/11. Severity: 2 Scope: 1	L 064		